Cougar Sound Spirits Healing Ctr.

77 Penacook Rd.

North Sutton, NH 03260

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize (Provider)_____ Provider Phone #_____

Medical Office:_____

Address:_____ Provider Fax #_____

City, State, Zip:_____

**To release health/medical record information of:**

_____ _____

Patient's Full Name Date of Birth

This information is to be released to:

Name: Dr. _____ Phone # 927-4526

Address: 77 Penacook Rd. Fax # 927-4101
North Sutton, NH 03260

**For the purpose of:** _____ **Permanent transfer to new provider**

_____ **Consultation with:** _____

_____ **Other** _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein excepted: _____

**This release includes specifically:**

| | | |
|---|---|---|
| Office Notes | Laboratory Reports | |
| Complete Record | Radiology Reports | |
| History & Physical | EKG | Other: _____ |

Covering records from:

1) The period from _____ to _____
2) Date of service _____

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE SIGNED, OR UNTIL THE FOLLOWING EVENT OR CONDITION:

_____

_____

SIGNATURE (person authorizing release): _____

Date of Signature: _____ Relationship to Patient: _____

**A FEE MAY BE ASSESSED TO PROCESS YOUR REQUEST. PLEASE ALLOW FIVE BUSINESS DAYS TO RELEASE YOUR RECORDS**